



PREFERRED DRUG LIST

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ALLERGY, ASTHMA, & COPD AGENTS

Inhaled Short-Acting Beta₂-Agonists

Preferred	Non-Preferred, Prior Authorization Required
AccuNeb® (albuterol)	Maxair® (pirbuterol)
ProAir HFA® (albuterol)	Xopenex® Inhaltion Solution (levalbuterol)
Proventil HFA® (albuterol)	Xopenex HFA® (levalbuterol)
Proventil® Inhalation Solution (albuterol)	
Ventolin HFA® (albuterol)	
Ventolin® Inhalation Solution (albuterol)	

Inhaled Long-Acting Beta₂-Agonists

*Clinical prior authorization may apply for all agents

Preferred	Non-Preferred, Prior Authorization Required
Foradil® (formeterol)	Arcapta® (indacaterol)
Serevent® (salmeterol)	Brovana® (arformoterol)
	Perforomist® (formoterol)

Inhaled Long-Acting Beta₂-Agonists/Corticosteroids

Preferred	Non-Preferred
Advair® Diskus (fluticasone/salmeterol)	Dulera® (formoterol/mometasone)
Advair® HFA (fluticasone/salmeterol)	
Symbicort® (budesonide/formoterol)	

Inhaled Corticosteroids

Preferred	Non-Preferred, Prior Authorization Required
Asmanex® (mometasone)	Pulmicort Respules® (budesonide) *> 7 years of age
Flovent® Diskus (fluticasone)	
Flovent® HFA (fluticasone)	
Pulmicort Respules® (budesonide) *≤ 6 years of age only	
QVAR® (beclomethasone)	
Non-Preferred	
	Alvesco® (ciclesonide)
	Pulmicort Flexhaler® (budesonide)

Intranasal Corticosteroids

Preferred	Non-Preferred, Prior Authorization Required
Flonase® (fluticasone)	Beconase® (beclomethasone)
Nasacort AQ® (triamcinolone) (branded products only)	Beconase AQ® (beclomethasone)
Nasonex® (mometasone)	Nasarel® (flunisolide)
Veramyst® (fluticasone)	Omnaris® (ciclesonide)
Non-Preferred	
	Vancenase® (beclomethasone)
	Vancenase AQ® (beclomethasone)
	Zetonna® (ciclesonide)
Non-Preferred	
	Rhinocort AQ® (budesonide)
	Triamcinolone Nasal Spray (generic products only)

Intranasal Antihistamines

Preferred	Non-Preferred
Astelin® (azelastine)	
Patanase® (olopatadine)	Astepro® (azelastine)



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Non-Sedating Antihistamines

Preferred	Non-Preferred, Prior Authorization Required
Claritin® (loratadine)	Allegra® (fexofenadine)
Claritin 24-hr Allergy® (loratadine)	Allegra® ODT (fexofenadine)
Claritin® Syrup (loratadine)	Clarinex® (desloratadine)
Zyrtec® (cetirizine)	Xyzal® (levocetirizine)
Zyrtec® Syrup (cetirizine)	The following drugs are covered for KBH only: Allegra-D® (fexofenadine/pseudoephedrine) Allegra-D24® (fexofenadine/pseudoephedrine) Clarinex-D 12-hour® (desloratadine/pseudoephedrine) Clarinex-D 24-hour® (desloratadine/pseudoephedrine)
Non-Preferred	
	Claritin Hives Relief® (loratadine)
	Claritin RediTabs® (loratadine)

Ophthalmic Antihistamine/Mast Cell Stabilizer Combinations

Preferred	Non-Preferred
Alaway® (ketotifen)	Bepreve® (bepotastine)
Refresh® (ketotifen)	Elestat® (epinastine)
Zaditor® (ketotifen)	Lastacaft® (alcaftadine)
	Optivar® (azelastine)
	Pataday® (olopatadine)
	Patanol® (olopatadine)

ANALGESICS

Long-Acting Opioids

Preferred	Non-Preferred
Morphine Sulfate ER (generic products only) OxyContin® (oxycodone SR)	Avinza® (morphine sulfate ER) Duragesic® (fentanyl) Embeda® (morphine/naltrexone) Exalgo® (hydromorphone HCL ER) Kadian® (morphine sulfate ER) MS Contin® (morphine sulfate ER) Opana ER® (oxymorphone) Ryzolt® (tramadol ER) Ultram ER® (tramadol ER)



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ANALGESICS (continued)

Muscle Relaxants (Skeletal)

Preferred	Non-Preferred, Prior Authorization Required
Flexeril® 10mg (cyclobenzaprine)	Amrix® (cyclobenzaprine ER)
Parafon Forte DSC® (chlorzoxazone)	Fexmid® 7.5mg (cyclobenzaprine)
Robaxin® (methocarbamol)	Flexeril® 5mg (cyclobenzaprine)
Robaxin-750® (methocarbamol)	Norflex® (orphenadrine)
Robaxisal® (methocarbamol/aspirin)	Norgesic® (orphenadrine/aspirin/caffeine)
	Norgesic® Forte (orphenadrine/aspirin/caffeine)
	Skelaxin® (metaxalone)

Muscle Relaxants (Spasticity)

Preferred	Non-Preferred, Prior Authorization Required
Lioresal® (baclofen)	Zanaflex® Capsules (tizanidine)
Zanaflex® Tablets (tizanidine)	Non-Preferred
	Dantrolene® (dantrolene)

Non-Steroidal Anti-Inflammatory Drugs (Ophthalmic)

Preferred	Non-Preferred
Acular® (ketorolac)	Bromday® (bromfenac)
Acular LS® (ketorolac)	Xibrom® (bromfenac)
Acuvail® (ketorolac)	
Nevanac® (nepafenac)	
Ocufen®(flurbiprofen)	
Voltaren® Ophthalmic (diclofenac)	

Non-Steroidal Anti-Inflammatory Drugs (Topical)

Preferred	Non-Preferred
Pennsaid® (diclofenac)	Flector® Patch (diclofenac epolamine)
Voltaren® Gel (diclofenac)	Sprix® Nasal Spray (ketorolac tromethamine)



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ANALGESICS (continued)

Non-Steroidal Anti-Inflammatory Drugs (Oral)

Preferred	Non-Preferred, Prior Authorization Required
Advil® (ibuprofen) Aleve® (naproxen) Anaprox® (naproxen) Anaprox DS® (naproxen) Ansaid® (flurbiprofen) Arthrotec® (diclofenac/misoprostol) Cataflam® (diclofenac potassium) Clinoril® (sulindac) Daypro® (oxaprozin) EC-Naprosyn® (naproxen) Feldene® (piroxicam)(branded products only) Indocin® (indomethacin) Lodine® (etodolac) Meclofenem® (meclofenamate) Mobic® (meloxicam) Motrin® (ibuprofen) Motrin-IB® (ibuprofen) Nalfon® (fenoprofen) Naprelan® (naproxen) Naprosyn® (naproxen) Orudis® (ketoprofen) Orudis® KT (ketoprofen) Oruvail® (ketoprofen) Ponstel® (mefenamic acid) Tolectin DS® (tolmetin) Tolectin 600® (tolmetin) Toradol®(ketorolac) (limited to a 5 day supply) Voltaren®(diclofenac sodium oral) Voltaren® XR (diclofenac sodium oral)	Relafen® (nabumetone) Non-Preferred Cambia® (diclofenac) Dolobid® (diflunisal) Indocin® SR (indomethacin) Lodine® XL (etodolac) Naprelan® CR Dosepak (naproxen) Piroxicam (generic products only) Vimovo®(naproxen/esomeprazole) Zipsor® (diclofenac)

Triptans	
Preferred	Non-Preferred, Prior Authorization Required
Amerge® (naratriptan) Imitrex® (sumatriptan) Relpax® (eletriptan) Sumatriptan generics	Frova® (frovatriptan) Zomig® (zolmitriptan) Zomig-ZMT® (zolmitriptan)
	Non-Preferred Alsuma® (sumatriptan) Axert® (almotriptan) Maxalt® (rizatriptan) Maxalt-MLT® (rizatriptan) Sumavel DosePro® (sumatriptan)



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ANTIHYPERTROPHIES

Bile Acid Sequestrants

Preferred	Non-Preferred
Colestid® (colestipol)	
Prevalite® (cholestyramine light)	
Questran® (cholestyramine)	
Questran Light® (cholestyramine light)	

Fibric Acid Derivatives

Preferred	Non-Preferred, Prior Authorization Required
Fenofibrate generics	Lofibra® (fenofibrate)
Lopid® (gemfibrozil)	Lipofen® (fenofibrate)
Tricor® (fenofibrate)	
Trilipix® (fenofibric acid)	
	Non-Preferred
	Fenoglide® (fenofibrate)
	Triglide® (fenofibrate)

HMG-CoA Reductase Inhibitors (Statins)

Preferred	Non-Preferred, Prior Authorization Required
Lipitor® (atorvastatin)	Altoprev® (lovastatin)
Lovastatin generics	Lescol® (fluvastatin)
Mevacor® (lovastatin)	Lescol XL® (fluvastatin)
Pravachol® (pravastatin)	Livalo® (pitavastatin)
Zocor® (simvastatin)	
	Non-Preferred
	Crestor® (rosuvastatin)

ANTI-INFECTIVES

Antiherpes Virus Agents

Preferred	Non-Preferred
Zovirax® (acyclovir) (oral dosage forms only)	Famvir® (famciclovir) Valtrex® (valacyclovir)

BIOLOGICS

Adult Rheumatoid Arthritis

*Clinical prior authorization may apply for all agents

Preferred	Non-Preferred, Prior Authorization Required
Enbrel® (etanercept) Humira® (adalimumab)	Actemra® (tocilizumab) Cimzia® (certolizumab) Kineret® (anakinra) Orencia® (abatacept) Remicade® (infliximab) Rituxan® (rituximab) Simponi® (golimumab)



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BIOLOGICS (continued)

Ankylosing Spondylitis

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Preferred	Non-Preferred, Prior Authorization Required
Enbrel® (etanercept) Humira® (adalimumab)	Remicade® (infliximab) Simponi® (golimumab)

Crohn's Disease

*Clinical prior authorization may apply for all agents

Preferred	Non-Preferred, Prior Authorization Required
Humira® (adalimumab)	Cimzia® (certolizumab)
Remicade® (infliximab)	Tysabri® (natalizumab)

Juvenile Idiopathic Arthritis

*Clinical prior authorization may apply for all agents

Preferred	Non-Preferred, Prior Authorization Required
Enbrel® (etanercept) Humira® (adalimumab)	Actemra® (tocilizumab) Orencia® (abatacept)

Plaque Psoriasis

*Clinical prior authorization may apply for all agents

Preferred	Non-Preferred, Prior Authorization Required
Enbrel® (etanercept) Humira® (adalimumab)	Amevive® (alefacept) Remicade® (infliximab) Stelara® (ustekinumab)

Psoriatic Arthritis

*Clinical prior authorization may apply for all agents

Preferred	Non-Preferred, Prior Authorization Required
Enbrel® (etanercept) Humira® (adalimumab)	Remicade® (infliximab) Simponi® (golimumab)

Ulcerative Colitis

*Clinical prior authorization may apply for all agents

Preferred	Non-Preferred, Prior Authorization Required
Remicade® (infliximab)	

CARDIOVASCULAR AGENTS

ACE Inhibitors

Preferred	Non-Preferred, Prior Authorization Required
Accupril® (quinapril) Capoten® (captopril) Lotensin® (benazepril) Monopril® (fosinopril) Prinivil® (lisinopril) Vasotec® (enalapril) Zestril® (lisinopril)	Aceon® (perindopril) Altace® (ramipril) Mavik® (trandolapril) Univasc® (moexipril)



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CARDIOVASCULAR AGENTS (continued)

ACE Inhibitor/Calcium Channel Blocker Combinations

Preferred	Non-Preferred, Prior Authorization Required
Lotrel® (benazepril/amlodipine)	Lexxel® (enalapril/felodipine) Tarka® (trandolapril/verapamil)

ARBs

Preferred	Non-Preferred, Prior Authorization Required
Benicar® (olmesartan)	Atacand® (candesartan)
Benicar HCT® (olmesartan/HCTZ)	Atacand HCT® (candesartan/HCTZ)
Cozaar® (losartan)	Teveten® (eprosartan)
Diovan® (valsartan)	Teveten HCT® (eprosartan/HCTZ)
Diovan HCT® (valsartan/HCTZ)	Non-Preferred
Hyzaar® (losartan/HCTZ)	Avalide® (irbesartan/HCTZ)
Micardis® (telmisartan)	Avapro® (irbesartan)
Micardis HCT® (telmisartan/HCTZ)	Edarbi® (azilsartan medoxomil)

ARB/Calcium Channel Blocker Combinations

Preferred	Non-Preferred
Azor® (amlodipine/olmesartan)	Twynsta® (amlodipine/telmisartan)
Exforge® (amlodipine/valsartan)	

Beta-Blockers

Preferred	Non-Preferred, Prior Authorization Required
Betapace® (sotalol)	Bystolic® (nebivolol)
Betapace AF® (sotalol AF)	Inderal® LA (propranolol XL)
Blocadren® (timolol)	Levatol® (penbutolol)
Coreg® (carvedilol)	Zebeta® (bisoprolol)
Corgard® (nadolol)	Non-Preferred
Inderal® (propranolol)	Coreg CR® (carvedilol CR)
InnoPran® XL (propranolol XL)	
Kerlone® (betaxolol)	
Lopressor® (metoprolol tartrate)	
Propranolol® Intensol (propranolol)	
Sectral® (acebutolol)	
Tenormin® (atenolol)	
Toprol® XL (metoprolol succinate)	
Visken® (pindolol)	

Calcium Channel Blockers (Dihydropyridines)

Preferred	Non-Preferred, Prior Authorization Required
Adalat CC® (nifedipine ER)	Adalat® (nifedipine IR)
Cardene® (nicardipine IR)	Cardene® SR (nicardipine SR)
DynaCirc® (isradipine IR)	Plendil® (felodipine)
DynaCirc® CR (isradipine CR)	Sular® (nisoldipine)
Norvasc® (amlodipine)	
Procardia® XL (nifedipine ER)	



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CARDIOVASCULAR AGENTS (continued)

Calcium Channel Blockers (Non-Dihydropyridines)

Preferred	Non-Preferred, Prior Authorization Required
Calan® (verapamil IR)	Cardizem CD® (diltiazem) (brand & AB-rated generics)
Calan SR® (verapamil SR)	Cardizem LA® (diltiazem) (brand & AB-rated generics)
Cardizem® (diltiazem IR)	Cardizem SR® (diltiazem) (brand & AB-rated generics)
Covera HS® (verapamil) (branded products only)	Dilacor XR® (diltiazem)
Diltia XT® (diltiazem) (brand & AB-rated generics)	Verelan PM® (verapamil) (brand & AB-rated generics)
Isoptin SR® (verapamil SR)	
Tiazac® (diltiazem) (brand & AB-rated generics)	
Verelan® (verapamil SR)	

CENTRAL NERVOUS SYSTEM AGENTS

Adjunct Antiepileptics

Preferred	Non-Preferred, Prior Authorization Required
Gabitril® (tiagabine)	Banzel® (rufinamide)
Keppra® (levetiracetam)	Onfi® (clobazam)
Keppra® XR (levetiracetam XR)	Vimpat® (lacosamide)
Lyrica® (pregabalin)	
Neurontin® (gabapentin)	
Zonegran® (zonisamide)	

Non-Benzodiazepine Sedative Hypnotics

Preferred	Non-Preferred, Prior Authorization Required
Ambien® (zolpidem)	Ambien® CR (zolpidem CR)
Zolpidem generics	Edular® (zolpidem)
	Intermezzo® (zolpidem)
	Sonata® (zaleplon)
Non-Preferred	
	Lunesta® (eszopiclone)

Non-Scheduled Novel Sleep Agents

Preferred	Non-Preferred
Rozerem® (ramelteon)	

DIABETIC AGENTS

AlphaGlucosidase Inhibitors

Preferred	Non-Preferred, Prior Authorization Required
Glyset® (miglitol)	Precose® (acarbose)

Biguanides

Preferred	Non-Preferred, Prior Authorization Required
Glucophage® (metformin) Metformin ER (generic products only)	Fortamet® (metformin ER) (branded products only) Glucophage® XR (metformin ER) (branded products only)



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DIABETIC AGENTS (continued)

Dipeptidyl Peptidase-4 Inhibitors

Preferred	Non-Preferred
Januvia® (sitagliptin) Onglyza® (saxagliptin) Tradjenta® (linagliptin)	

Meglitinides

Preferred	Non-Preferred, Prior Authorization Required
Starlix® (nateglinide)	Prandin® (repaglinide)

Incretin Mimetics

*Clinical prior authorization may apply to all agents

Preferred	Non-Preferred, Prior Authorization Required
Byetta® (exenatide)	Bydureon® (exenatide ER)

Insulin Delivery Systems

Preferred	Non-Preferred, Prior Authorization Required
Humalog® multi-dose vial Humalog® Mix multi-dose vial Humulin N® multi-dose vial Humulin R® multi-dose vial Humulin 70/30® multi-dose vial Novolin N® multi-dose vial Novolin R® multi-dose vial Novolin 70/30® multi-dose vial NovoLog® multi-dose vial, PenFill, & FlexPen NovoLog® Mix multi-dose vial, PenFill, & FlexPens Velosulin BR® multi-dose vial	Humalog® (excluding multi-dose vials) Humalog® Mix (excluding multi-dose vials) Humulin N® (excluding multi-dose vials) Humulin R® (excluding multi-dose vials) Humulin 70/30® (excluding multi-dose vials) Novolin N® (excluding multi-dose vials) Novolin R® (excluding multi-dose vials) Novolin 70/30® (excluding multi-dose vials) Velosulin BR® (excluding multi-dose vials)

Long-Acting Insulin (Vials Only)

Preferred	Non-Preferred
Lantus® (insulin glargine)	Levemir® (insulin detemir)

2nd Generation Sulfonylureas

Preferred	Non-Preferred, Prior Authorization Required
Amaryl® (glimepiride) DiaBeta® (glyburide) Glucotrol® (glipizide) Glucotrol XL® (glipizide XL) Glucovance® (glyburide/metformin) Glynase PresTab® (micronized glyburide) Micronase® (glyburide)	Metaglip® (glipizide/metformin)



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DIABETIC AGENTS (continued)

Thiazolidinediones

Preferred	Non-Preferred
Actos® (pioglitazone)	Avandamet® (rosiglitazone/metformin)
ACTOplus Met® (pioglitazone/metformin)	Avandaryl® (rosiglitazone/glimepiride)
ACTOplus Met XR® (pioglitazone/metformin)	Duetact® (pioglitazone/glimepiride)
Avandia® (rosiglitazone)	

GASTROINTESTINAL AGENTS

H₂ Antagonists

Preferred	Non-Preferred, Prior Authorization Required
Pepcid® (famotidine)	Axid® (nizatidine)
Zantac® (ranitidine)	Non-Preferred
Zantac EFERdose® (ranitidine)	Tagamet® (cimetidine)

Pancreatic Enzyme Replacements

Preferred	Non-Preferred
Creon® (pancrelipase)	Pancreaze® (pancrelipase)
Zenpep® (pancrelipase)	

Proton Pump Inhibitors

Preferred	Non-Preferred, Prior Authorization Required
Prilosec® (omeprazole)	AcipHex® (rabeprazole)
Protonix® (pantoprazole)	Dexilant® (dexlansoprazole)
	Nexium® (esomeprazole)
	Nexium® Suspension (esomeprazole)
	Prevacid® Suspension (lansoprazole)
	Prilosec® Suspension (omeprazole)
Non-Preferred	
	Prevacid® (lansoprazole)
Non-Preferred	Prevacid SoluTab® (lansoprazole)

Serotonin 5HT₃ Antagonists

Preferred	Non-Preferred, Prior Authorization Required
Zofran® (ondansetron)	Anzemet® (dolasetron)
Zofran ODT® (ondansetron)	Gransol® (granisetron)
	Kytril® (granisetron)
	Sancuso® (granisetron)
Non-Preferred	
	Zuplenz® (ondansetron)

GOUT AGENTS

Xanthine Oxidase Inhibitors

Preferred	Non-Preferred, Prior Authorization Required
Zyloprim® (allopurinol)	Uloric® (febuxostat)



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INJECTABLES

Growth Hormones

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Preferred	Non-Preferred, Prior Authorization Required
Genotropin® (somatropin)	Humatrope® (somatropin)
Genotropin® MiniQuick (somatropin)	Norditropin® (somatropin)
Omnitrope® (somatropin)	Norditropin® FlexPro (somatropin)
Saizen® (somatropin)	Norditropin® Nordiflex (somatropin)
Tev-Tropin® (somatropin)	Nutropin® (somatropin)
	Nutropin® AQ (somatropin)
	Nutropin AQ NuSpin® (somatropin)

Erythropoiesis-Stimulating Agents

Preferred	Non-Preferred
Epogen® (epoetin alfa)	Aranesp® (darbepoetin alfa)
Procrit® (epoetin alfa)	

OPHTHALMIC AGENTS

Ophthalmic Prostaglandin Analogs

Preferred	Non-Preferred, Prior Authorization Required
Travatan Z® (travoprost)	Lumigan® (bimatoprost)
Xalatan® (latanoprost)	

OSTEOPOROSIS AGENTS

Bisphosphonates

Preferred	Non-Preferred, Prior Authorization Required
Fosamax® (alendronate)	Actonel® (risedronate)
Fosamax Plus D® (alendronate/cholecalciferol)	Actonel® with Calcium (risedronate/calcium)
	Atelvia® (risedronate)
Non-Preferred	
	Boniva® (ibandronate)

UROLOGIC AGENTS

Anticholinergics

Preferred	Non-Preferred, Prior Authorization Required
Detrol® (tolterodine)	Ditropan XL® (oxybutynin ER)
Detrol® LA (tolterodine ER)	Oxytrol® Patch (oxybutynin)
Ditropan® (oxybutynin)	Sanctura® (trospium)
Toviaz® (fesoterodine)	Sanctura XR® (trospium ER)
Vesicare® (solifenacina)	Urispas® (flavoxate)
Non-Preferred	
	Enablex® (darifenacin)
	Gelnique® Gel (oxybutynin)